Rhode Island Department of Health

Public Health Briefings

Proposed Skin Cancer Screening Recommendations

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Objective

The Rhode Island Department of Health assembled an Expert Panel on Cancer Screening to advise the Department on revising the State's current cancer control plan, published in 1989. (1) After reviewing the current screening recommendations of national organizations and the most recent pertinent literature, the Panel proposed a recommendation for skin cancer screening to be incorporated in a revised cancer control plan scheduled for community review in December, 1996.

Methods

- Review current skin cancer screening recommendations of national organizations.
- Review the most recent literature pertinent to skin cancer screening.
- Discuss.
- Propose skin cancer screening recommendations for the State's cancer control plan.
- Write a simple rationale for the proposed skin cancer recommendations.
- Invite comments on the proposed recommendations with rationale.

Current Recommendations:

U.S. Preventive Services Task Force

- Does not recommend for or against routine screening for skin cancer by primary care providers.
- Suggests that clinicians remain alert for skin lesions with malignant features, particularly patients with established risk factors for skin cancer.
- Recommends to consider referring patients at substantially increased risk of malignant melanoma to skin cancer specialists for evaluation and surveillance.

American Cancer Society

- Recommends monthly skin self-examination for all adults and physician skin examinations every 3 years in persons 20 to 39 years old and annually in persons 40 years or older.

American Academy of Dermatology

- Recommends regular screening visits for skin cancer.

National Institutes of Health Consensus Panel

- Recommends regular screening visits for skin cancer.
- Recommends that some family members of patients with melanoma be enrolled in surveillance programs.

Canadian Task Force on the Periodic Health Exam

- Does not recommend for or against routine screening for skin cancer by primary care providers.
- Suggests that total skin examinations for a very select subgroup of individuals at high risk of malignant melanoma may be prudent.

American Academy of Family Physicians

- Recommends complete skin examination for adolescents and adults with increased recreational or occupational exposure to sunlight, a family or personal history of skin cancer, or clinical evidence of precursor lesions.

American Medical Association

- Does not recommend for or against routine screening for skin cancer by primary care providers.

Proposed Rhode Island Recommendations

- **Do not recommend for or against routine screening for skin cancer by primary care providers.**
- **Clinicians should remain alert for skin lesions with malignant features (i.e., asymmetry, border irregularity, color variability, diameter > 6mm, or rapidly changing lesions) when examining patients for other reasons, particularly patients with established risk factors, including clinical evidence of melanocytic precursor or marker lesions, large numbers of common moles, immunosuppression, a family or personal history of skin cancer, substantial cumulative lifetime sun exposure, intermittent intense**

sun exposure or severe sunburns in childhood, freckles, poor tanning ability, light skin, hair, and eye color.

- **Recommend to consider referring patients at substantially increased risk of malignant melanoma to dermatologists specializing in skin cancer for evaluation and surveillance. Persons at substantially increased risk for malignant melanoma include those with menalocytic precursor or marker lesions, e.g., atypical moles [also called dysplastic nevi], certain congenital nevi, familial atypical mole, and melanoma syndrome. (2)**

Rationale for Proposed Recommendations

When the State's current cancer control plan was being developed in the late 1980s, the committee charged with this task determined that there was insufficient evidence to recommend for or against routine skin cancer screening of asymptomatic persons by health care providers. Since that time, little new information has become available to change that position. The relevant literature has been summarized by the U.S. Preventive Services Task Force (2) as follows:

- The vast majority of skin lesions (over 95%) are either basal cell or squamous cell carcinomas. Both "are highly treatable and rarely metastasize." The case fatality of these lesions is low. About 2,100 annual deaths result from over 760,000 annual cases.
- The effectiveness of early detection for reducing mortality or disfigurement has not been demonstrated for basal cell or squamous cell carcinomas. There is no evidence that basal cell or squamous cell carcinomas detected by screening are more amenable to treatment and cure than those which present clinically.
- The accuracy of skin cancer screening by health care providers other than dermatologists is low.

Nonetheless, clinicians and their patients are urged to remain alert for the clinical manifestations of skin cancers, especially those which may prove to be malignant melanoma, a far more dangerous cancer than either basal cell or squamous cell carcinoma. Furthermore, consideration to refer patients at substantially increased risk of malignant melanoma to dermatologists specializing in skin cancer is recommended because:

- Screening by dermatologists for malignant melanoma appears to reduce the thickness of tumors diagnosed; survival is related to the thickness of tumors at the time of diagnosis.
- The accuracy of screening for malignant melanoma is greater among dermatologists specializing in skin cancer than among general dermatologists.
- The burden of malignant melanoma (incidence and mortality) is growing steadily. The case fatality of malignant melanoma is much higher than the

case fatality of basal cell or squamous cell carcinoma. About 7,200 annual deaths result from about 34,000 annual cases.

References

1. Rhode Island Department of Health. *Cancer Control Rhode Island. Plan for 1990-1992.* Providence, RI: Rhode Island Department of Health, 1989.
2. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services, 2nd ed.* Baltimore: Williams and Wilkins, 1996.